IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. BUTCH OTTER, GOVERNOR
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

February 9, 2010

Casey Meza
Clearwater Valley Hospital & Clinics
301 Cedar Street
Orofino, ID 83544

RECEIVED
FEB 18 2010
FACILITY STANDARDS

RE: Clearwater Valley Hospital & Clinics, provider #131320

Dear Mr. Meza:

This is to advise you of the findings of the complaint survey at Clearwater Valley Hospital & Clinics which was concluded on January 27, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the POC is effective in bringing the hospital into compliance, and that the hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

After you have completed your Plan of Correction, return the original to this office by **February 22, 2010**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208) 334-6626.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/mlw

Enclosures

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 131320 | A. BUILDING _____ B. WING _____ | C 01/27/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLEARWATER VALLEY HOSPITAL & CLINICS | 301 CEDAR STREET OROFINO, ID 83544 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| C 000 | INITIAL COMMENTS<br><br>The following deficiency was cited during the complaint survey of your hospital. Surveyors conducting the investigation were:<br><br>Gary Guiles, RN, HFS, Team Leader<br>Susan Costa, RN, HFS<br><br>CAH = Critical Access Hospital<br>DNS = Director of Nursing Services<br>POC = Plan of Care | C 000 | RECEIVED<br>FEB 18 2010<br>FACILITY STANDARDS | |
| C 298 | 485.635(d)(4) NURSING SERVICES<br><br>A nursing care plan must be developed and kept current for each inpatient.<br><br>This STANDARD is not met as evidenced by:<br>Based on staff interview and review of medical records and hospital policies, it was determined the CAH failed to ensure complete nursing care plans were developed for 5 of 11 patients (#1, #2, #5, #7, and #11) whose medical records were reviewed. This interfered with the CAH staff's ability to provide consistent patient care. The findings include:<br><br>1. Patient #1's medical record documented a 19 year old male who was admitted to the hospital on 11/24/09. He was discharged on 11/25/09. His History and Physical Examination, dated 11/24/09, stated his diagnosis was peritonsillar abscess and dehydration. His tonsils were surgically removed on 11/24/09. His medical record contained a blank nursing POC. This was confirmed by interview with the DNS on 1/26/10 at 4:05 PM.<br><br>2. Patient #2's medical record documented a 30 year old male who was admitted to the hospital on | C 298 | please see attached | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

CEO 2/16/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| C 298 | Continued From page 1<br>10/19/09. He was discharged on 10/22/09. His History and Physical Examination, dated 10/19/09, stated his diagnoses included spina bifida, hydro-ureter with a history of recent ureterostomy surgery, abdominal pain, hydronephrosis, and blood clots to his lower extremity. The only problem listed on his nursing POC, dated 10/20/09, was "Risk for further blood clots [related to] non-therapeutic [laboratory] results." His kidney problems and pain were not addressed. This was confirmed by interview with the DNS on 1/26/10 at 4:05 PM.<br><br>3. Patient #5's medical record documented a 45 year old female who was admitted to the hospital on 10/02/09. She was discharged on 10/05/09. Her History and Physical Examination, dated 10/02/09, stated her diagnosis was abdominal pain. Her medical record did not contain a nursing POC. This was confirmed by interview with the DNS on 1/26/10 at 4:05 PM.<br><br>4. Patient #7's medical record documented a 56 year old male who was admitted to acute care services at the hospital from swing bed status on 4/03/09. He was transferred to another hospital on 4/08/09. His discharge summary, dated 4/08/09, listed his discharge diagnoses as chronic obstructive pulmonary disease and atrial fibrillation. The discharge summary stated he was readmitted to acute care services for an "Acute colonic pseudo obstruction." The summary stated he had a nasogastric tube and a rectal tube. Patient #7 had a Kardex which listed the rectal tube, oxygen orders and other ongoing orders. His medical record did not contain a nursing POC. This was confirmed by interview with the DNS on 1/26/10 at 4:05 PM. | C 298 | | |

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| **CLEARWATER VALLEY HOSPITAL & CLINICS** | **301 CEDAR STREET OROFINO, ID 83544** |

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| C 298 | Continued From page 2<br>5. Patient #11's medical record documented a 78 year old female who was admitted to the hospital on 11/14/09. She was discharged on 4/08/09. Her discharge summary, dated 11/24/09, stated she had colon and gallbladder surgery on 11/14/09. Following surgery, the discharge summary stated she had a nasogastric tube and operative drains. The discharge summary stated she had a period of confusion following surgery. Patient #11 had a Kardex which listed the post-operative orders. She did not have a nursing POC. This was confirmed by interview with the DNS on 1/26/10 at 4:05 PM.<br><br>6. The DNS was interviewed on 1/26/10 at 4:05 PM. She stated the hospital did not have a current policy that addressed POCs.<br><br>The hospital did not maintain complete nursing POCs. | C 298 | | |

Bureau of Facility Standards

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| B 000 | 16.03.14 Initial Comments<br><br>The following deficiency was cited during the complaint survey of your hospital. Surveyors conducting the investigation were:<br><br>Gary Guiles, RN, HFS, Team Leader<br>Susan Costa, RN, HFS<br><br>DNS = Director of Nursing Services<br>POC = Plan of Care | B 000 | | |
| BB175 | 16.03.14.310.03 Patient Care Plans<br><br>03. Patient Care Plans. Individual patient care plans shall be developed, implemented and kept current for each inpatient. Each patient care plan shall include but is not limited to: (10-14-88)<br><br>a. Nursing care treatments required by the patient; and (10-14-88)<br><br>b. Medical treatment ordered for the patient; and (10-14-88)<br><br>c. A plan devised to include both short-term and long-term goals; and (10-14-88)<br><br>d. Patient and family teaching plan both for hospital stay and discharge; and (10-14-88)<br><br>e. A description of socio-psychological needs of the patient and a plan to meet those needs. (10-14-88)<br><br>This Rule is not met as evidenced by:<br>Based on staff interview and review of medical records and hospital policies, it was determined the hospital failed to ensure complete POCs were developed for 5 of 11 patients (#1, #2, #5, #7, and #11) whose medical records were reviewed. | BB175 | RECEIVED<br>FEB 18 2010<br>FACILITY STANDARDS | |

Bureau of Facility Standards

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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| BB175 | Continued From page 1<br>This interfered with the hospital staff's ability to provide consistent patient care. The findings include:<br><br>1. Patient #1's medical record documented a 19 year old male who was admitted to the hospital on 11/24/09. He was discharged on 11/25/09. His History and Physical Examination, dated 11/24/09, stated his diagnosis was peritonsillar abscess and dehydration. His tonsils were surgically removed on 11/24/09. His medical record contained a blank POC. This was confirmed by interview with the DNS on 1/26/10 at 4:05 PM.<br><br>2. Patient #2's medical record documented a 30 year old male who was admitted to the hospital on 10/19/09. He was discharged on 10/22/09. His History and Physical Examination, dated 10/19/09, stated his diagnoses included spina bifida, hydro-ureter with a history of recent ureterostomy surgery, abdominal pain, hydronephrosis, and blood clots to his lower extremity. The only problem listed on his POC, dated 10/20/09, was "Risk for further blood clots [related to] non-therapeutic [laboratory] results." His kidney problems and pain were not addressed. This was confirmed by interview with the DNS on 1/26/10 at 4:05 PM.<br><br>3. Patient #5's medical record documented a 45 year old female who was admitted to the hospital on 10/02/09. She was discharged on 10/05/09. Her History and Physical Examination, dated 10/02/09, stated her diagnosis was abdominal pain. Her medical record did not contain a POC. This was confirmed by interview with the DNS on 1/26/10 at 4:05 PM.<br><br>4. Patient #7's medical record documented a 56 | BB175 | | |

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| BB175 | Continued From page 2<br>year old male who was admitted to acute care services at the hospital from swing bed status on 4/03/09. He was transferred to another hospital on 4/08/09. His discharge summary, dated 4/08/09, listed his discharge diagnoses as chronic obstructive pulmonary disease and atrial fibrillation. The discharge summary stated he was readmitted to acute care services for an "Acute colonic pseudo obstruction." The summary stated he had a nasogastric tube and a rectal tube. Patient #7 had a Kardex which listed the rectal tube, oxygen orders and other ongoing orders. His medical record did not contain a POC. This was confirmed by interview with the DNS on 1/26/10 at 4:05 PM.<br><br>5. Patient #11's medical record documented a 78 year old female who was admitted to the hospital on 11/14/09. She was discharged on 4/08/09. Her discharge summary, dated 11/24/09, stated she had colon and gallbladder surgery on 11/14/09. Following surgery, the discharge summary stated she had a nasogastric tube and operative drains. The discharge summary stated she had a period of confusion following surgery. Patient #11 had a Kardex which listed the post-operative orders. She did not have a POC. This was confirmed by interview with the DNS on 1/26/10 at 4:05 PM.<br><br>6. The DNS was interviewed on 1/26/10 at 4:05 PM. She stated the hospital did not have a current policy that addressed POCs.<br><br>The hospital did not maintain complete POCs. | BB175 | | |

IDAHO DEPARTMENT OF
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DEBRA RANSOM, R.N.,R.H.I.T., Chief
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3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

FILE COPY

February 9, 2010

Casey Meza
Clearwater Valley Hospital & Clinics
301 Cedar Street
Orofino, ID 83544

Provider #131320

Dear Mr. Meza:

On **January 27, 2010**, a complaint survey was conducted at Clearwater Valley Hospital & Clinics. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00004071**

**Allegation #1**: Patient received poor medical care.

Findings: An unannounced visit was made to the hospital on 1/26/10 and 1/27/10. Eleven medical records were reviewed. Hospital policies were reviewed. Staff were interviewed.

All 11 medical records contained documentation demonstrating physicians were responsive to patient needs and patients were closely monitored.

One medical record documented a 56 year old male who was admitted to the hospital on 3/16/09 with a diagnosis of Chronic Obstructive Pulmonary Disease. He was treated with antibiotics, Prednisone, and aspirin as an anticoagulant. His condition slowly improved and he was transferred to swing bed status on 3/21/09 and was discharged from the hospital on 3/23/09. The discharge summary from the swing bed medical record, dated 3/23/09, stated the patient had received eight full days of antibiotics and the physician chose not to continue the medication.

The patient returned to the emergency room on 3/25/09 complaining of increased shortness of breath and fever. He was admitted to the hospital and started on Lovenox as an anticoagulant and another antibiotic. He was transferred to swing bed status on 3/30/09. The Lovenox was discontinued on 3/31/09 and he was started on Coumadin as an anticoagulant. Laboratory tests were performed daily from 3/30/09 through 4/03/09 to ensure his anticoagulant medications were within therapeutic ranges. More laboratory tests were performed after 4/03/09 to monitor his anticoagulant medications. A physician's History and Physical Examination, dated 4/03/09, noted the patient had bruises on his abdomen from the Lovenox injections.

The patient experienced abdominal distension and pain and he was readmitted to acute care status on 4/03/09. He was diagnosed with an acute colonic ileus or pseudo-obstruction (intestinal blockage). He was treated for this and his abdominal complaints decreased. However, as his abdomen got better, his respiratory status declined. Then this gradually improved. On 4/08/09, the patient was transferred to a larger hospital per his request. Physician progress notes were extensive. They documented the patient was closely monitored and problems were treated as they came up.

It was also noted the hospital had an active peer review process. The patient's case had been reviewed by the medical staff because he had been re-hospitalized after being discharged.

No evidence was found to indicate inadequate care was provided.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

**Allegation #2**: Patient asked to change doctors but was not allowed to do so.

Findings: Ten medical records were reviewed. One medical record documented a 56 year old male who was admitted to the hospital on 3/16/09 with a diagnosis of Chronic Obstructive Pulmonary Disease. He was transferred to swing bed status on 3/21/09 and was discharged from the hospital on 3/23/09. He was readmitted to the hospital on 3/25/09 complaining of increased shortness of breath and fever. He had complications from a pseudo-obstruction. He was eventually transferred to a larger hospital on 4/08/09.

A progress note by the patient's attending physician, dated 3/26/09, stated the patient was unhappy and wanted to change physicians. The note stated the patient had requested a specific physician but said this physician was on leave. The note stated the current physician would attempt to arrange for the transfer of care when the requested physician returned.

The next progress note to discuss this topic was the attending physician's note on 4/06/09. It stated the attending physician had spoken to the requested physician. The note said the requested physician stated he would accept the patient after the patient's hospitalization, when the patient could be established at the new physician's clinic. The note stated the patient had been informed of the decision.

A progress note by a different physician, dated 4/07/09 at 5:55 PM, stated the patient demanded transfer to another hospital. The note stated the physician had placed a call to the physician at the receiving hospital and was awaiting a return call. The medical record stated the patient was transferred to the receiving hospital the next day.

The patient's attending physician was interviewed on 1/26/10 at 5:05 PM. He stated the patient requested a certain physician who was not available at the time of the request. He stated when the requested doctor returned, the requested doctor wanted to wait until the patient was discharged from the hospital and would then accept the patient's care. The attending physician stated the patient accepted that plan. The attending physician stated the requested physician would only accept the patient in transfer after discharge from the hospital. The attending physician stated the patient requested transfer to another hospital a day or two later. The attending physician stated he facilitated the transfer.

None of the other records reviewed revealed instances where patients wished to change physicians.

The hospital attempted to transfer the patient's care but the preferred physician was not available. Later, the preferred physician refused to accept the patient while he was still an inpatient. While the incident may have occurred, no evidence was found during the investigation to indicate the physicians acted inappropriately.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

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3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

February 12, 2010

Casey Meza
Clearwater Valley Hospital & Clinics
301 Cedar Street
Orofino, ID 83544

Provider #131320

Dear Mr. Meza:

On **January 27, 2010**, a complaint survey was conducted at Clearwater Valley Hospital & Clinics. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00004279**

**Allegation #1**: The OR manager is not qualified or trained for her job. In addition, Operating Room Technicians are not properly trained.

Findings: An unannounced visit was made to the hospital on 1/26/10 and 1/27/10. Eleven medical records were reviewed. A tour of the surgical suite and central supply area was conducted. Hospital policies were reviewed. Staff were interviewed. Personnel files were reviewed.

A tour of the operating room was conducted on 1/26/10 beginning at 11:55 AM. Two surgical cases had been performed that morning. A registered nurse had participated in both surgeries that day. The tour was conducted by another registered nurse who was the Clinical Coordinator for Surgery and in charge of the department. The Clinical Coordinator stated four registered nurses circulated on surgical cases. She said they had all been trained for the operating room by the hospital. She stated a registered nurse participated in all surgeries.

The Clinical Coordinator also said three technicians worked in surgery. One of these had a certificate for completing a surgical technologist program.

The other two had been trained by the hospital. This met the requirements for both federal and state regulations. The Clinical Coordinator stated the hospital was in the process of hiring staff in order for surgeries to be staffed by all registered nurses.

Staff were qualified and trained for the positions they held.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

**Allegation #2**: Central Processing is sloppy in its processing of sterile equipment.

Findings: A tour of the Central Processing Department was conducted following a surgery, at noon on 1/26/10. Surgical instruments were processed in surgery according to a set protocol. They were then taken to central processing where the cleaning process was completed. The instruments were wrapped and sterilized using an autoclave.

Policies and procedures were current in the Central Processing Department. Staff had been trained in the hospital and were knowledgeable about processes. Appropriate records were kept.

Infection control records were reviewed. No infections related to surgery were documented in 2009. The hospital was in compliance with state and federal hospital requirements in relation to Central Processing.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/mlw